TASC

Technical Assistance and Services Center

Flex Program Hour Highlights

Date: *July 12, 2000*
Topic: *EMS – State Models*
Facilitator: *Terry Hill, TASC*
Guests: *Roger Twitchell, Florida Department of Health*
Serge Dihoff, North Carolina Office of Research, Demonstrations & Rural Health Dev.
Deb Moreno, Rural EMS Institute, North Dakota
Julie Schoenman and Penny Mohr, Project HOPE

Project HOPE – Project HOPE's role in the Flex Program tracking project has been to track what states are doing with Flex funds in the area of EMS, and to identify any EMS-related changes that may be taking place at the CAH/community level as a result of the hospital conversions. In the first year they visited North Carolina, Georgia, Texas, Wisconsin, and Maine. One theme they have seen is that first year Flex funds have been used to do surveys to determine community EMS needs. Subsequent years' funds will be used to implement them.

Texas – Julie Schoenman of Project Hope gave a summary of EMS activities in Texas. Texas is already part of a successful regional trauma system and they have required all CAHs to participate in the program. The benefits are twofold: (1) CAHs become more involved in networks, and (2) other participants learn what services CAHs are capable of providing in emergency. Texas has also created a matching scholarship program. Approximately 25-30 scholarships of a few thousand dollars each are awarded to rural communities for EMT and paramedic training. Recipients must serve in that rural community after completing their training. Participation rules have just been approved and training will begin this fall.

Georgia – Penny Mohr of Project HOPE, outlined Georgia's EMS initiatives. Counties in Georgia are small with a limited economic base. Georgia is using its Flex funds to develop a multi-county/cross-county system for sharing of resources. In its ideal form, a regional 911 system will be headquartered in one county, billing will become centralized, and emergency vehicles will be positioned on the basis of call volume, not political boundaries. Out of the six-county region, two counties are currently participating. Only one of these counties has EMS availability so the money is being used to train first responders and upgrade equipment in the county without an EMS system. There are no CAHs in these two counties, but there are two CAHs in the target six-county region.

Florida – Roger Twitchell, who worked in EMS for 10 years before joining the Office of Rural Health, gave an update on Florida's EMS activities. The State EMS Directors Association recently conducted a national survey of EMS services. Roger has created a survey to be sent to Directors to validate what was submitted from Florida in response to the national survey. Of Florida's 240 services, 31 are considered rural and these services (including urban back-up coverage services) have received an educational packet from the state office concerning rural health issues and critical access hospitals. He has also developed a PowerPoint presentation about the benefits of integrating EMS into the CAH program. Because urban

providers do operate in rural counties, they are included in rural planning activities. Initiatives outside of the CAH program include an $8 million grant program that has been around since 1987. Recipients don't need to be members of a rural health network to receive funds. However they must be network members to tap into any Flex funds.

North Carolina – Serge Dihoff summarized a North Carolina EMS success story. Halifax County had five independent volunteer squads providing emergency ambulance services; but response time was high and billing/collection efforts were ineffectual. County Commissioners passed a 2½ percent tax assessment that paid for 60 percent of the operating costs of replacing volunteers with fully paid EMT-paramedic level staff. A sixth squad was added to help reduce response time in the traditionally slow-to-respond area. Since these changes have been made, ambulance calls have increased 32%, average "out of shoot" time decreased 63%, and overall response time decreased 33%. Flex funds have been used to support a countywide EMS billing system to eliminate inequities in billing and collection. The centralized billing system was implemented in January 2000 and forecasts are for $1.2 million in revenue collections with a 62 percent collection rate. Flex dollars are paying for a portion of the salaries of the staff and supplies during this start-up period. They will also support a centralized inventory control system that has not yet been implemented.

North Dakota – Deb Moreno of the Rural EMS Initiative (REMSI) described their collaboration between the North Dakota SORH and state EMS office. Main activities in their project have included two surveys: (1) EMS provider survey sent to 5,800 EMS providers to identify demographics, job satisfaction, job turnover and retention, and personnel recruitment factors; and (2) EMS squad survey sent to 300 squads to examine issues of recruitment and retention problems, facility and supply needs, and interest in using project services. REMSI also conducts workshops, provides technical assistance to EMS squads, and is drafting a manual on recruitment and retention of EMS personnel. CAH-specific efforts include using Flex dollars for training and equipment. Purchased computers are used for billing and also for access to continuing education credits on-line for EMTs. With monies from the next grant cycle, they hope to network two EMS units and two ambulance services to work with CAHs as they try to "beef up" their ALS service.